EDMUND G. BROWN JR.
Attorney General of California
LINDA K. SCHNEIDER
Supervising Deputy Attorney General
RITA M. LANE
Deputy Attorney General
State Bar No. 171352
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2614
Facsimile: (619) 645-2061
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DANUTA TORONCZAK BERND** P.O. Box 2786 Ramona, CA 92065 Registered Nurse License No. 452288 Respondent.	Case No. 2009 - 318 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 31, 1990, the Board of Registered Nursing issued Registered Nurse License Number 452288 to Danuta Toronczak Bernd (Respondent). The Registered Nurse license was in full force and effect at all times mentioned in the Accusation and will expire on November 30, 2009, unless renewed.

///

///

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1443, states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

8. California Code of Regulations, title 16, section 1443.5 states:

> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:
>
> (1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

STATEMENT OF FACTS

10. Patient D.D., a 61 year old African-American female, was admitted to the University of California, San Diego (UCSD), Medical Center, Intensive Care Unit (ICU) from June 5, 2003 to July 4, 2003. Patient D.D. was admitted to the ICU with multiple medical problems. She had a history of morbid obesity (325 pounds) with some disability. Patient D.D.'s medical records indicate that patient D.D. had been sitting in a chair for two straight days prior to being admitted to the hospital. Her medical records also note that patient D.D.'s skin was intact on admission to the ICU.

11. On June 7, 2003, patient D.D. was placed in a Bariatric bed (adjustable bed for larger, overweight patients).

12. On June 9, 2003, ankle blisters and lower extremity bullae (blisters) were noted in the Physician Progress Notes for patient D.D.

13. On June 11, 2003, the first documentation of a Stage 1 skin tear on patient D.D.'s coccyx was noted on the skin diagram on the Nursing ICU flow sheet. Patient D.D. was assessed as a low risk under the Braden Skin Risk Assessment scale for predicting pressure ulcer risk. An Allevyn dressing was applied at that time.

14. On June 12, 2003, a skin tear on the right buttock was listed as a Stage 2 pressure ulcer on the Nursing ICU flow sheet. That day, patient D.D. was assessed as a high risk using the Braden Skin Risk Assessment scale.

15. On June 13, 2003, the Braden scale risk was documented as "moderate" and the skin integrity sheet documented only "coccyx" with no stage or size.

16. On June 14, 2003, the Nursing ICU flow sheet reflected the wound on patient D.D.'s right buttock "was healing" and it was classified as stage 2/1. There was an order to "apply skin care under both breasts due to skin breakdown; turn every 2 hours PRN (as necessary) and avoid pressure to coccyx and buttocks." There was no nursing documentation reflecting any skin breakdown under the breasts.

17. On June 16, 2003, there was documentation on the Nursing ICU flow sheet that the coccyx wound was open and it was staged as a 2 or 3.

18. On June 18, 2003, it was documented on the Nursing ICU flow sheet that patient D.D.'s coccyx skin was "torn off."

19. On June 21, 2003, from 7:00 a.m. to 7:30 p.m., Respondent took care of patient D.D. while she was in the ICU.

20. On June 22, 2003, there was day shift nursing documentation on the Nursing ICU flow sheet, identifying multiple pressure ulcers 1) on the left buttock, 2) on the right buttocks and 3) on the right thigh.

21. On June 23, 2003, in the Physician Ortho Progress Note, there was a description of a small superficial ulcer on patient D.D.'s heel.

22. On June 24, 2003, the day shift reported on the Nursing ICU flow sheet there were Stage 3 pressure ulcers on patient D.D.'s left and right buttocks and the right thigh.

///

23. On June 26, 2003, in the Physician's Progress Notes, Internal Medicine charted "the patient has a decub and skin breakdown under breast-wound care begun-will document/take pics." The Internal Medicine Service Attending wrote a progress note stating "sore outside left chest wall, sacrum and newly noted decub -will increase nursing care to decub."

24. On June 27, 2003, the Internal Medicine Service intern documented "several large areas of decubs; low grade fever due to decubs??? Will stage when available to turn." On the Infectious Disease progress note, it was charted "Pics of back decubs noted." There was an order for a wound consultant and to photograph the wounds. On the Nursing ICU flow sheet, pressure ulcers were documented on the buttocks as "large variety, stage 1&2, the left breast, and a left heel pressure ulcer." Allevyn dressing was listed. A pressure reducing air mattress was ordered.

25. On June 28, 2003, the Medical Resident wrote "stage 2 decub sacrum bilaterally. Try to dc (discontinue) rectal tube soon to keep decubs clean from diarrhea."

26. On June 29, 2003, the Internal Medicine intern documented "low grade fevers -source due to decubs??? 3 large decubs, stage 2 gluteal, perianal area. Wound care, frequent shifting, air mattress."

27. On June 30, 2003, from 7:00 a.m. to 7:00 p.m., Respondent took care of patient D.D. while she was in the ICU.

28. On July 3, 2003, the Internal Medicine Attending charted "continuous decub care; airbed."

29. On July 4, 2003, patient D.D. was discharged to Evergreen Skilled Nursing facility. The physician note discharged patient D.D. with one of her diagnoses as being decubitus ulcers. Evergreen Skilled Nursing staff documented the following areas of skin breakdown on the day of patient D.D.'s transfer to their facility from UCSD Medical Center:

1. Coccyx - 7 cm x 3.5cm
2. Left Ischium -7cm x 5cm
3. Right Ischium – 10cm x 6cm
4. Right Ischium - 5cm x 2cm
5. Right Ischium - 2cm x 1.5cm

6. Left Heel - 5cm x 2.5cm

7. Right Heel - 7cm x 8cm

8. Left Lower Leg, medial aspect - 5cm x 4cm

9. Left Lower Leg, medial aspect - 2 cm x 2cm

10. Left Lower Leg, medial aspect - 1 cm x 1.5cm

11. Left Lower Leg, medial aspect - 1 cm x 1.5cm

12. Right Thigh - 1cm x 1cm

13. Right Thigh - 3cm x 1.5 cm

14. Right Thigh - 2cm x 1cm

15. Right thigh medial - 7cm x 2cm

16. Right groin - 1cm x 1cm

17. Right Breast - 10cm x 10 cm

18. Left Breast - 10 cm x 10cm

19. Right Upper Back - 7cm x .5cm

The above list of skin breakdown on patient D.D.'s admission to Evergreen Skilled Nursing facility was much more detailed and extensive than what was charted at UCSD Medical Center.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

30. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on June 21 and 30, 2003, Respondent was guilty of incompetence in her care of patient D.D. within the meaning of Regulation 1443, as follows:

31. On June 21, 2003, Respondent failed to assess patient D.D. for risk of skin breakdown using the Braden Skin Risk Assessment Scoring Tool that is on the UCSD Medical Center ICU flow sheet.

32. On June 21, 2003, Respondent failed to assess and plan for pressure relief for patient D.D.'s skin by using another mattress to give patient D.D. the appropriate support surface for her skin.

33. On June 30, 2003, Respondent failed to assess and add the Braden Skin Risk Assessment Scale for patient D.D. Respondent also did not initiate any interventions to prevent further skin breakdown for patient D.D.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

34. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, in that on June 21 and 30, 2003, Respondent committed acts constituting negligence in her care of patient D.D. as follows:

35. On June 21, 2003, Respondent failed to document in the medical record that she turned patient D.D. every two hours during Respondent's 12-hour shift.

36. On June 21, 2003, Respondent failed to assess and document the status of patient D.D.'s skin after the patient returned to the ICU after receiving a procedure.

37. On June 21, 2003, Respondent failed to carry out an assessment of patient D.D., failed to determine the cause, or develop a plan or interventions, after noting leg granulation on patient D.D.

38. On June 30, 2003, Respondent failed to provide documentation on location, appearance, size, staging, drainage, or dressings on any of patient D.D.'s pressure ulcers. Respondent failed to assess and provide follow up care to patient D.D. Respondent also failed to communicate to the physicians regarding the condition of patient D.D.'s pressure ulcers, wound care and shifts in weight.

39. On June 30, 2003, Respondent failed to document that she moved or turned patient D.D. during her shift.

40. On June 30, 2003, Respondent failed to document that she provided direct care to patient D.D. for her multiple pressure ulcers that were sighted and documented in the medical record on June 29, 2003 by the physician. Respondent failed to document that she provided wound care to patient D.D., that she frequently shifted or turned patient D.D., and that an air mattress was provided to patient D.D.

///

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 452288, issued to Danuta Toronczak Bernd;

2. Ordering Danuta Toronczak Bernd to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 6/16/09

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2008802886
80363002.doc